STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	15E187	A. BUILDING 00 B. WING	05/25/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIMMONS LOVING CARE HEALTH FACILITY	700 E 21ST AVE GARY, IN46407

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F0000	This visit was for the Investigation of Complaints IN00090539 and IN00090585. Complaint IN00090539 - Substantiated. Federal/State deficiencies related to the allegations are cited at F272, F314, and F323. Complaint IN00090585 - Substantiated. Federal/State deficiencies related to the allegations are cited at F272, F314, and F323. Survey dates: May 24 and 25, 2011 Facility number: 000368 Provider number: 15E187 AIM number: 100275220 Survey team: Janelyn Kulik, RN Census bed type: NF: 22 Total: 22 Census payor type: Medicaid: 21 Other: 1 Total: 22 Sample: 6	F0000	June 14, 2011 Ms. Kim Rhoades, R.N. Director Indiana State Department of Health 2 North Meridian Street Indianapolis, IN 46204 Plan of Correction Dear Ms. Rhoades, I am submitting CMS-2567 plan of correction as a credible allegation of compliance to the May 25, 2011 health survey. All corrections will be completed by June 24, 2011. The Q.A. Committee will meet monthly to ensure all deficient practices of the facility have been corrected. After all deficiencies are recognized as being corrected by the State Board of Health Q.A. meetings will resume meeting quarterly but will reserve the right to meet more frequently depending upon the needs of the facility. We are still having problems with the transition to the MDS 3.0 system. The company is still trying to work out the problems in this new system which is causing a great delay in response time for customer support.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	These deficiencies also reflect State findings cited in accordance with 410 IAC 16.2. Quality review completed 6/2/11 by Jennie Bartelt, RN.		I am sorry I am submitting this via fax and mail but I could not log in on the computer system to send the report. Please contact me if you have any questions. Sincerely, Mrs. Herberta B. Miller Administrator	

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F0272 SS=D	The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. Based on record review and interview, the facility failed to assess a resident for risks of falling for 1 of 1 resident who fell in a sample of 6 (Resident #E) and accurately assess the risk for pressure sores and assess pressure sores for 1 of 2 residents reviewed	F0272	F Tag 272 Resident Comprehensive Assessment 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 1 fall assessment was completed immediately and nurse admission record updated with fall risk assessment. Resident D record was reviewed and the Braden Scale Assessment was discussed	06/24/2011

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	with pressure sores in a sample of 6 (Resident #D) Findings include: 1. The record for Resident #D was reviewed on 5/25/11 at 8:37 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, seizure disorder, dementia, hypertension, arthritis, depression, cerebrovascular accident (stroke), chronic obstructive pulmonary disease (COPD), and congestive heart failure. A Braden Scale Assessment (scale to assess risk for pressure sores) was completed as follows: on 3/11/11 with a score of 17 which indicated low risk for pressure sores; on 3/17/11 with a score of 16 which indicated a low risk for pressure sores; on 3/27/11 with a score of 16 which indicated a low risk for pressure sores; on 4/3/11 with a score of 14 which indicated a moderate risk for pressure sores; and on 4/14/11 with a score of 13		with all licensed nursing staff. It was noted that the Braden Scale Assessment was not accurate and should have indicated an higher risk for development of pressure areas since she had been a prior resident with pressure areas. MDS was reviewed with emphasis on wound documentation. The wound assessment sheet was also reviewed and emphasis put on always placing one wound area on one sheet because it is easier to track the healing process and course of treatment. Resident D record is a closed record therefore we only reviewed it as a learning tool. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All medical records of residents fall assessments were audited and no other resident was found deficient. No other resident was affected. Medical records of residents with Pressure Areas will be assessed and documented accordingly. All residents Braden Scales were reviewed for accuracy and no other resident was affected. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. In Service on documentation for residents Fall Assessments on accuracy and completion was done. In	

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	which indicated a moderate risk for pressure sores. The Annual Minimum Data Set Assessment (MDS), dated 3/11/11, indicated the resident sometimes understands and was sometimes understood. She was severely impaired cognitively indicated she never or rarely made decisions. The resident was a limited assist with transfers and bed mobility indicating she she was highly involved in the activity and with a one person assist. She was frequently incontinent of bowel and bladder. She had problems with her long and short term memory. The resident was not at risk for developing pressure sores. There were no pressure sores and had no healed pressure sores. A nursing note, dated 3/17/11 at 8:00 p.m., indicated, "resident toileted by staff, excoriation noted to r (right) buttock and dark dry scab in center of old healed decub (decubitus) to r (right) hip		Service on Braden Scale and Plan of Care was reviewed along with the proper completion of the MDS according to skin and pressure areas. The weekly wound assessment was also reviewed. Documentation policy of Fall Assessment, Braden Scale, MDS, and Weekly Wound Assessment will be review and provided to nurses. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. D.O.N. designee will monitor all admission nurse admission records and fall risk assessments upon admission and quarterly fall risk assessments. How the corrective action will be monitored to ensure the deficient practice will not recur. A R.N. will be assigned to audit and monitor documentation of residents with Pressure Areas, Braden Scale, Braden Scale Plan of Care and MDS upon admission, significant change and quarterly. The Weekly Wound Assessment will be monitored weekly and reviewed with wound nurse monthly. Director of Nursing and or designee will audit and monitor monthly and determine future in-service training needs. The D.O.N. will discuss progress and concerns to the Q.A. Committee and the committee will determine effectiveness of the following policy and procedures: Fall Assessment, Braden Scale, Braden Scale Plan of Care,	

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	surrounding tissue WNL (within normal limits)." Scab measured 1 cm (centimeter) by 0.7 cm by 0 cm. The physician was informed, and an order was received for zinc oxide to excoriation twice a day and as need until resolved. Family notified. A nursing note, dated 3/20/11 at 7:00 p.m., indicated an open area was noted to right buttock measuring 1 cm by 0.7 cm by 0 cm. The physician was informed and an order to continue zinc oxide to buttocks was received. The family was informed. A nursing note, dated 3/28/11 at 5:00 a.m., indicated, "blister to right heel noted." At 3:45 p.m., the podiatrist was in to see the resident. The resident's shoes were too big. The family was made aware and family was to bring in new shoes. A nursing note, dated 4/7/11 at 2:00 p.m., indicated, "blister to r (right) heel remains, skin hard, dry, et (and) dark in color with not		Weekly Wound Assessment. 5. Completion Date: 6/24/2011 ADDENDUM The corrective action taken for resident E was a fall assessment was completed and a lap buddy is applied when up in wheelchair to prevent her from leaning to far foward. No other falls have occured with Resident E. The corrective action for resident with pressure areas was having each pressure area noted on one page to track the progess or decline of the wound. The wound nurse monitors the wound monthly and prn and the physician will monitor the wound monthly and prn.The corrective action taken for residents having the potential to be affected by falls is as follows: Fall Risk Assessment is completed upon admission and updated quarterly and as needed. If a resident falls a post fall assessment is done to determine any risk factors causing the resident to fall. If a resident is at risk for falling Physical Therapy will be consulted to determine what anti-falling devices are needed such as lap buddy, alarm sensor, low bed, bolsters and or wedges. The corrective action taken for residents having the potential for pressure areas is as follows: Braden Scale is done to determine residents who are high risk and pressure relieving devices are used. The wound is monitored and if the area	

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	drainage noted." A nursing note, dated 4/13/11 at 5:00 a.m., indicated, "resident appears to be sleeping. Eyes open when name called. Responds verbally." The resident was somewhat lethargic. At 5:15 a.m. during morning care the resident was more lethargic. An order was received to sent to ER for evaluation and treatment. Family notified. A Patient Transfer sheet dated 4/13/11, indicated 5:00 a.m., "Resident appears to be sleep (sic). Open eyes when name called. Verbally responsive. But very lethargic. Has be (sic) getting more lethargic approx (sic) x (times) 5 days. Resident has almost healed decubs (sic) to r (right) buttock and hip. Healing blister to r (right) heel." A nursing note, dated 4/14/11 at 2:16 p.m., indicated the resident returned to the facility. "R (right)		worsens the resident is refered to the wound clinic and plan of care is determined and followed. The resident will continue to follow up with the wound clinic until wound is healed.The systemic measures put into place are all resident who are a high fall risk are monitored each shift for anti-falling devices. This is dicussed during shift to shift report and tour check. The resident is monitored throughout each shift 24 hours per day. Each shift is monitored by the charge nurse and any falls or incidents are reported to the D.O.N. immediately. The D.O.N. will monitor the fall risk assessments and anti fall devices weekly times 1 month then monthly for six months to ensure ongoing compliance. The systemic measures put into place are all residents had an updated Braden Scale and Plan of Care completed. Residents with high risk of pressure sore developement is discussed during shift to shift report and tour check. The resident is monitored each shift for pressure relieving devices such as heel protectors, air mattress, gel cushions and put to bed to releive pressure, they are turned and repositioned every 2 hours and as needed. The resident is assessed each shift and if a pressure area is noted the physician is contacted to determine the course of treatment. The Licensed Nurse will monitor skin sheets weekly	

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	heel with two ruptured blisters noted, dry, hard and dark in color." The areas measured 4.5 cm by 3.5 cm by 0 cm and 3.5 cm by 4 cm by 0 cm. "Reopened blister to r (right) hip measured at 1 cm by 1 cm by 0 cm." A new order was received to apply santyl (wound treatment) daily and cover with dry dressing and arginaid (nutritional supplement) one box twice a day. At 7:00 p.m., the wound nurse was notified of the areas. A nursing note, dated 4/23/11 at 7:34 p.m., indicated the right hip wound measured 2.5 cm by 2.0 cm by 0 cm and the right heel remained dark with hardened area to blister. A nursing note, dated 4/25/11, indicated the resident was turned and repositioned. An odor was noted to the right hip wound with a small amount of serosanguinous drainage noted to dressing and pad in bed. A dressing was applied per orders and the area will continue to be monitored. At 7:30 a.m., the		and for residents with pressure areas the wound is monitored daily. The D.O.N. will monitor weekly wound sheets weekly and monitor progress or regression of pressure areas weekly ongoing until pressure area is resolved.	

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	wound continued to drain. An order was received to go to wound clinic as soon as possible. At 2:00 p.m., upon making rounds, the resident was noted to have an open area to her coccyx with a small amount of bleeding noted. The area measured 1 cm by 1 cm by 0.2 cm. There was no odor. The physician was notified, and an order was received to start Keflex (antibiotic) 500 mg (milligrams) one by mouth four times a day for 14 days and Propass (nutritional supplement) mix with water daily, Clean wound with normal saline and cover with duoderm (dressing) every three days. The family was notified. A nursing note, dated 4/26/11 at 6:00 a.m., indicated, "dressing change to r (right) hip. Foul smelling drainage noted. Brownish in color." The resident's right heel remains dark and hard. At 8:00 a.m., the resident was to go to the wound clinic for evaluation of open areas to right hip, right heel, and coccyx. The family was notified.			

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	At 12:30 p.m., the resident was out to wound clinic and staff accompanied. A Wound Clinic Note, dated 4/26/11, indicated the resident had a temperature of 100.5 degrees. The right hip wound measured 3.0 cm by 2.4 cm by 1.2 cm, the granulation texture was pale/gray, and there was a moderate amount of purulent exudate with odor. The periwound appearance was erythema (red) and the necrosis was present. The right heel wound measured 9.0 cm by 3.5 cm by 0.1 cm. The area was necrotic with no drainage. It was dry gangrene. The coccyx area measured 1.0 cm by 0.9 cm by 0.1 cm. The periwound area was intact. There was no drainage or odor. A hospital History and Physical, dated 4/26/11, indicated the resident was transferred with fever and dehydration. The impression was Alzheimer disease, history of past strokes, decubitus right hip,			

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	sepsis, dehydration, and necrosis of right heel. The plan: "The patient will be started on IV (intravenous) antibiotics. Subsequently, debridement and possible g-tube. Will have Infectious Disease consult with the primary physician." A Weekly Wound Assessment Flow Record indicated 3/17/11 wound identified with the box marked yes. The location was the right buttock, staged indicated excoriation. The tissue was red. the treatment was zinc oxide and she had an air mattress and gel cushion as pressure relieving devices. On 3/27/11 the form indicated the area was healed. A Weekly Wound Assessment Flow Record indicated 3/17/11 the box was checked for yes that a wound was identified. The location indicated right buttock and the the stage was un-stageable (scab). There was no assessment noted of the tissue color and no			

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	measurement was documented. There was no drainage or odor. The wound edges were in normal limits and the surrounding tissue was normal. The treatment was zinc oxide and an air mattress and gel cushion were used for pressure relieving devices. On 3/27/11 the form indicated a check mark by the wound identified. The location was right buttock and the stage healing. The tissue color was cab off solid pink tissue. The area measured 2 cm by 4 cm by 0 cm. There was no drainage or odor. The wound edges were within normal limits and the surrounding tissue was within normal limits. the area was improved. The treatment was was zinc oxide and pressure relieving devices included an air mattress and gel cushion. On 3/28/11 there was a check in the box yes there was a wound identified. It was staged as a blister and the tissue color was fluid filled. there were no measurements indicated. There was no drainage and on odor. The wound edges were attached and the			

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	surrounding tissue was normal. The treatment of heel protectors and an air mattress was the pressure relieving device used. On 4/3/11 the box marked yes was check for a wound was identified. it was un-stageable and the blister had ruptured. There was nothing assessed for tissue color or measurements. There was a small amount of drainage that was serous in color. the edges were attached and the surrounding tissue was within normal limits. The treatment was zinc oxide, dressing and tape and heel protectors. The pressure relieving devices were low air mattress and heel protectors. There were no other Weekly Wound Assessment Flow Record for the right hip in the resident's chart or in the skin treatment book until 4/14/11 and no other flow records for the resident's right heel. A Weekly Wound Assessment Flow Record dated 4/14/11 indicated a check was placed in the box that a			

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	wound was identified to the right hip the tissue color was spongy and the area measured 1 cm by 1 cm by undetermined. There was a small amount of serosanguinous drainage (contains serum and blood) with no odor. The edges were attached and the surrounding tissue was normal. On 4/19/11 the right hip measured 1 cm by 1 cm by undetermined. The tissue was spongy with serosanguinous drainage and no odor. The treatment was changed to santyl cover with hydrogel and foam dressing twice a day. On 4/25/11 the right hip was pale red and measured 2.5 by 2 cm by undetermined. There was a small amount of serosanguinous drainage that had an odor and the wound was deteriorating. On 4/25/11 a wound had been identified to the coccyx area that was a Stage II. The area was beefy red measuring 1 cm by 1 cm by 0.2 cm. there was a small amount of serous (serum) drainage with no odor. A Weekly Wound Assessment Flow			

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	Record dated 3/20/11, indicated a check was placed in the box yes for wound identified to right buttock at a Stage II. The tissue was red and the area measured 1 cm by 0.7 cm by 0 cm. there was no drainage or odor. The edges were attached and the surrounding tissue was normal. The treatment was continue zinc oxide and the pressure relieving devices were air mattress and gel cushion. On 3/27/11 the right buttock area was a Stage II red in color, measuring 1 cm by 0.7 cm by 0 cm with no drainage or odor. The wound edges were attached and the surrounding tissue was normal. The treatment and pressure relieving devices were the same. On 4/3/11 the Right buttock was a Stage II red in color measuring 1 cm by 0.7 cm by O cm. There was no drainage no odor, the wound edges were attached and the surrounding tissue was normal. The treatment and pressure relieving devices were not changed. On 4/10/11 the right buttock was a Stage I measuring 0.7 cm by 0.3 cm			

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	by 0 cm. The tissue had epithelial growth with no drainage or odor. The edges were attached and the surrounding tissue was normal. There was no change in the treatment or the pressure relieving devices. There were no other Weekly Wound Assessment Flow Records for the right buttock. The Weekly Pressure Area, Blister or Skin Tear Measurement Schedule Policy was provided by the Director of Nursing on 5/25/11 at 1:15 p.m. The purpose: "To ensure the resident's skin condition heals to the optimal level as possible with skin becoming intact. Procedure: "1. Complete "Braden Scale" assessment form on admission, reassess quarterly there after and upon significant change. 2. If resident is identified at risk for alteration in skin integrity provide precautions/interventions to decrease the risk of pressure areas,			

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	blister, or skin tear. 3. Document specific problems, interventions and goals on resident's care plan. 4. Review and update the care plan with scheduled revisions of resident's condition changes. 5. If pressure area, blister or skin tear occurs, assess and document the weekly wound assessment: A. Location. B. Stage etc. C. size (cm) length x (times) width. D. wound depth (cm). E. Odor. F. Drainage. G. Admitted with pressure area or facility acquired. H. Physician notified and treatment order. I. Family notification. All stage III, IV and areas with eschar tissue will be referred to the Wound Nurse or Wound Clinic. 2. Weekly measurements will be recorded on the weekly wound assessment sheet. 3. Pressure Area Long Sheet will be completed monthly and given to the Director of nursing for Quality Assurance Meeting." On 5/25/11 at 1:00 p.m. the Director of Nursing (DoN) was interviewed. She indicated that the			

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	above Weekly Wound Assessment Flow Record that included the right buttock and the right heel should not have indicated right buttock but right hip. She further indicated there must be a sheet of Weekly Wound Assessments Flow Record missing for the right hip and right heel. At this time the DoN indicated that there had been two areas to the right buttock: the 3/17/11 area that healed on 3/27/11, and the open area that was found on the right buttocks on 3/20/11. She further indicated she would look into where the Weekly Wound Assessment Flow Records were and provide the forms. On 5/25/11 at 2:00 p.m. the Weekly Wound Assessment Flow Records were requested again from the DoN. The DoN indicated she knew the missing Weekly Wound Assessment Flow Records had not been provided and would provide them. On 5/25/11 at 3:15 p.m. the DoN			

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	was interviewed. She indicated that when the resident returned to the facility on 4/14/11 the resident's hip wound was spongy and the scab was no longer present and there was a thin film like membrane where the scab had been located. "It was like there was something under the thin membrane." We were not going to break the membrane but the treatment was changed to santyl in hopes of opening it up. The wound nurse was in on 4/19/11 and changed the dressing again, then overnight on 4/25/11 the wound changed and an order was received to go to the wound clinic. The soonest we could get her in was the next day. At 3:45 p.m. she requested the Social Service Director/Human Resource Manager to get the QA (quality assurance papers). The DoN indicated these forms would have the wound measurement that had been requested earlier in the day. She indicated this would be part of the resident's record because they were copies of the Weekly			

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	Wound Assessment Flow Record. The copies were provided. The DoN then indicated that the Weekly Wound Assessment Flow Records were different from the forms previously provided, because she told staff that all information on one skin area was to be on one form. She did not want different wound areas on the same form. There was additional data provided on these forms that was not on the original forms that had been provided. At this time she also indicated the physician had seen the resident's wounds on 3/30/11 but had not been back in to the facility due to personal reasons but the facility had the wound nurse come in and see the resident. 2. The record for Resident #E was reviewed on 5/24/11 at 11:45 a.m. The resident was admitted to the facility on 4/4/11. Her diagnoses included, but were not limited to, diabetes mellitus, coronary artery disease, hypertension, left above the knee amputation, and right			

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	below the knee amputation. The Admission Assessment for dated 4/4/11 at 4:00 p.m. indicated the section "History of Falls" was not completed. There were no boxes checked for the following areas: "if checked, further evaluation required per facility policy," "no history of falls," "fell in past 30 days," and "fell in past 31-180 days." A nursing note, dated 4/30/11 at 6:49 a.m., indicated resident completed dinner and propelled self via wheelchair to room along with peers. The resident was found on floor, near door, crying. Staff assessed the resident for bruising, and bleeding was noted to right forefinger. Interview with Social Service Director/Human Resource Manager on 5/25/11 at 8:25 a.m., indicated all area of the Resident Nursing Assessment form need to be completed. No area should be			

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	blank. Interview with LPN #1 on 5/25/11 at 8:35 a.m., indicated all areas of the Resident Nursing Assessment form were to be completed when a resident was admitted to the facility. No area should be blank. Interview with the Director of Nursing on 5/25/11 at 3:15 p.m., indicated the area on the Resident #E's resident nursing assessment form was blank and it should not have been, however there may have been another fall assessment completed. The facility had new computer programs and the assessment could be in the computer. At the exit conference on 5/25/11 at 4:00 p.m. the Director of Nursing indicated there was no fall assessment completed on the resident when she was admitted to the facility. This federal tag relates to			

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	Complaints IN00090539 and IN00090585. 3.1-31(c)(2)			
F0314 SS=G	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on record review and interview, the facility failed to completely and accurately assess the resident's risk for pressure ulcers and failed to accurately assess and clearly document pressure ulcers when identified, in accordance with facility policy for 1 of 2 residents reviewed with pressure ulcers in a sample of 6. (Resident #D) The deficient practice resulted in Resident #D's developing multiple pressure ulcers, including a pressure ulcer which declined	F0314	F Tag 314 Treatment/SVCS To Prevent/Heal Pressure Sores 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Braden Scale Assessment and Weekly Wound Assessment was reviewed for resident D. The review was for in-service training since this was a closed record. All residents with pressure areas were immediately reviewed for accuracy. All residents Braden Assessments were reviewed to	06/24/2011

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	to a wound with purulent drainage and odor requiring hospitalization for care. Findings include: The record for Resident #D was reviewed on 5/25/11 at 8:37 a.m. The resident's diagnoses included, but were not limited to, Alzheimer's disease, seizure disorder, dementia, hypertension, arthritis, depression, cerebrovascular accident (stroke), chronic obstructive pulmonary disease (COPD), and congestive heart failure. A Braden Scale Assessment (scale to assess risk for pressure sores) was completed as follows: on3/11/11 with a score of 17 which indicated low risk for pressure sores; on 3/17/11 with a score of 16 which indicated a low risk for pressure sores; on 3/27/11 with a score of 16 which indicated a low risk for pressure sores; on 4/3/11 with a score of 14 which indicated a moderate risk for pressure sores; and on 4/14/11 with a score of 13 which indicated a moderate risk for pressure sores. The Annual Minimum Data Set Assessment, dated 3/11/11, indicated the resident sometimes understands and was sometimes understood. She was severely impaired cognitively, indicating she never		ensure accuracy. All moderate and high risk residents have been identified properly. It was determined that Resident D status had changed and she was high risk for pressure sore development because of declining medical condition. Resident D was once a hospice resident admitted with pressure sores and peg tube, whom we had rehabilitated and was discharged off of hospice and returned home. Resident decline was sudden and returning to her prior hospice medical status with pressure areas and need for peg tube. We are aggressively assessing the residents with declining medical conditions. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All residents with high and moderate risk of pressure sore development were identified and will be closely monitored and assessed. No other resident was affected. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not recur. In Service on documentation for residents Braden Scale Assessments on accuracy and completion was done. In Service on Braden Scale and Plan of Care was reviewed along with the proper completion of the MDS according to skin and	

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	or rarely made decisions. The resident was a limited assist with transfers and bed mobility,indicating she she was highly involved in the activity and with a one person assist. She was frequently incontinent of bowel and bladder. She had problems with her long and short term memory. The resident was not at risk for developing pressure sores. There were no pressure sores and had no healed pressure sores. A nursing note, dated 3/17/11 at 8:00 p.m., indicated, "resident toileted by staff, excoriation noted to r (right) buttock and dark dry scab in center of old healed decub (decubitus) to r (right) hip surrounding tissue WNL (within normal limits)." Scab measured 1 cm (centimeter) by 0.7 cm by 0 cm. The physician was informed and an order was received for zinc oxide to excoriation twice a day and as need until resolved. Family notified. A physician order, dated 3/17/11 at 8:00 p.m., indicated apply zinc oxide to excoriation to right buttock and right hip three times a day and as needed until resolved. A nursing note, dated 3/20/11 at 7:00 p.m., indicated an open area was noted to right buttock measuring 1 cm by 0.7 cm		pressure areas. The weekly wound assessment was also reviewed. Documentation policy of Braden Scale, and Weekly Wound Assessment will be review and provided to nurses. 4. How the corrective action will be monitored to ensure the deficient practice will not recur. D.O.N. designee will monitor all admission nurse admission records skin assessments and determine risk factors for development of pressure areas and quarterly thereafter unless significant change is noted. A R.N. will be assigned to audit and monitor documentation of residents with Pressure Areas, Braden Scale, Braden Scale Plan of Care and MDS upon admission, significant change and quarterly. The Weekly Wound Assessment will be monitored weekly and reviewed with wound nurse monthly. Director of Nursing and or designee will audit and monitor monthly and determine future in-service training needs. The D.O.N. will discuss progress and concerns to the Q.A. Committee and the committee will determine effectiveness of the following policy and procedures: Fall Assessment, Braden Scale, Braden Scale Plan of Care, Weekly Wound Assessment. Addendum The corrective action for resident with pressure areas was having each pressure area noted on one page	

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	by 0 cm. The physician was informed and an order to continue zinc oxide to buttocks was received.. The family was informed. A nursing note, dated 3/22/11 at 8:00 p.m., indicated the resident was positioned on her left side, "open area to r (right) hip, pink edges no drainage or odor present." A nursing note, dated 3//24/11 at 1:00 a.m., indicated, "dark scab remains to r (right) hip. A nursing note, dated 3/28/11 at 5:00 a.m., indicated, "blister to right heel noted." At 3:45 p.m. the podiatrist was in to see the resident. The resident's shoes were to big. The family was made aware and family was to bring in new shoes. A physician order, dated 3/28/11, indicated observe blister to right heel daily for negative changes. The blister appears to be resolving naturally. The resident was to acquire proper fitting shoes. A nursing note, dated 3/29/11 at 8:00 p.m., indicated the open area to right buttock and right hip were healing without difficulty, there was epithelia tissue present and no drainage or odor.		to track the progess or decline of the wound. The wound nurse monitors the wound monthly and prn and the physician will monitor the wound monthly and prn.The corrective action taken for residents having the potential for pressure areas is as follows: Braden Scale is done to determine residents who are high risk and pressure relieving devices are used. The wound is monitored and if the area worsens the resident is refered to the wound clinic and plan of care is determined and followed. The resident will continue to follow up with the wound clinic until wound is healed.The systemic measures put into place are all residents had an updated Braden Scale and Plan of Care completed. Residents with high risk of pressure sore developement is discussed during shift to shift report and tour check. The resident is monitored each shift for pressure relieving devices such as heel protectors, air mattress, gel cushions and put to bed to releive pressure, they are turned and repositioned every 2 hours and as needed. The resident is assessed each shift and if a pressure area is noted the physician is contacted to determine the course of treatment. The Licensed Nurse will monitor skin sheets weekly and for residents with pressure areas the wound is monitored daily. The D.O.N. will monitor	

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	A nursing note, dated 3/30/11 at 3:45 p.m., indicated the physician was in to see resident. A nursing note, dated 4/3/11 at 8:33 p.m., indicated, "fluid filled blister ruptured." The physician was informed and a new order was received, "applied to r (right) heel, to rupt (ruptured) blister, cover with dry gauze and secure with tape, apply heel protectors". A physician order dated 4/3/11, indicated zinc oxide to right heel to ruptured blister twice a day and as needed until healed, cover with dry gauze and secure with tape, and heel protectors. A nursing note, dated 4/7/11 at 2:00 p.m., indicated, "blister to r (right) heel remains, skin hard, dry, et (and) dark in color with not drainage noted." A nursing note, dated 4/8/11 at 8:30 p.m., indicated right buttock and right hip healing well without complications and new epithelial growth present. The right heel remains hard and dry. A nursing note, dated 4/12/11 at 5:00 p.m., indicated the open area to the right buttock had resolved.		weekly wound sheets weekly and monitor progress or regression of pressure areas weekly ongoing until pressure area is resolved.	

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	A nursing note, dated 4/13/11 at 5:00 a.m., indicated, "resident appears to be sleeping. Eyes open when name called. Responds verbally." The resident was somewhat lethargic. At 5:15 a.m. during morning care the resident was more lethargic. An order was received to sent to ER for evaluation and treatment. Family notified. A Patient Transfer sheet dated 4/13/11, indicated 5:00 a.m., "Resident appears to be sleep (sic). Open eyes when name called." Verbally responsive. But very lethargic. Has be (sic) getting more lethargic approx (sic) x (times) 5 days. Resident has almost healed decubs (sic) to r (right) buttock and hip. Healing blister to r (right) heel." A nursing note, dated 4/14/11 at 2:16 p.m., indicated the resident returned to the facility. "R (right) heel with two ruptured blisters noted, dry, hard and dark in color." The areas measured 4.5 cm by 3.5 cm by 0 cm and 3.5 cm by 4 cm by 0 cm. "Reopened blister to r (right) hip measured at 1 cm by 1 cm by 0 cm." A new order was received to apply santyl (wound treatment) daily and cover with dry dressing and arginaid (nutritional supplement) one box twice a day. At 7:00 p.m. the wound nurse was notified of the areas.			

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A nursing note, dated 4/15/11 at 2:00 p.m., indicated called the wound nurse in regards to the resident's wounds to her right heel and right hip and left message.

A nursing note, dated 4/19/11 at 2:30 p.m., indicated the wound nurse changed order for wounds. The resident's family was notified.

A physician order dated 4/19/11, indicated a right hip, pressure-un-stageble full thickness area to be treated with santyl, hydrogel and bordered foam dressing twice a day.

A nursing note, dated 4/23/11 at 7:34 p.m., indicated the right hip wound measured 2.5 cm by 2.0 cm by 0 cm and the right heel remained dark with hardened area to blister.

A nursing note, dated 4/25/11, indicated the resident was turned and repositioned. An odor was noted to the right hip wound with a small amount of serosanguinous drainage noted to dressing and pad in bed. A dressing was applied per orders and the area will continue to be monitor. At 7:30 a.m. the wound continued to drain. An order was received to go to wound clinic as soon as possible. At 2:00 p.m. upon making rounds the resident was noted to

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	have an open area to her coccyx with a small amount of bleeding noted. The area measured 1 cm by 1 cm by 0.2 cm. There was no odor. The physician was notified and an order was received to start Keflex (antibiotic) 500 mg (milligrams) one by mouth four times a day for 14 days and Propass (nutritional supplement) mix with water daily, Clean wound with normal saline and cover with duoderm (dressing) every three days. The family was notified. A nursing note, dated 4/26/11 at 6:00 a.m., indicated, "dressing change to r (right) hip. Foul smelling drainage noted. Brownish in color." The resident's right heel remains dark and hard. At 8:00 a.m. the resident was to go to the wound clinic for evaluation of open areas to right hip, right heel, and coccyx. The family was notified. At 12:30 p.m., the resident was out to wound clinic, and staff accompanied. A Wound Clinic note, dated 4/26/11, indicated the resident had a temperature of 100.5 degrees. The right hip wound measured 3.0 cm by 2.4 cm by 1.2 cm the granulation texture was pale/gray, and there was a moderate amount of purulent exudate with odor. The periwound appearance was erythema (red) and the necrosis was present. The right heel			

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	15E187	A. BUILDING 00 B. WING	05/25/2011

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	wound measured 9.0 cm by 3.5 cm by 0.1 cm. The area was necrotic with no drainage. It was dry gangrene. The coccyx area measured 1.0 cm by 0.9 cm by 0.1 cm. The peri wound area was intact. There was no drainage or odor. A hospital History and Physical, dated 4/26/11, indicated the resident was transferred with fever and dehydration. The impression was Alzheimer disease, history of past strokes, decubitus right hip, sepsis, dehydration, and necrosis of right heel. The plan: "The patient will be started on IV (intravenous) antibiotics. subsequently, debridement and possible g-tube. Will have Infectious Disease consult with the primary physician." A care plan initiated on 3/17/11, indicated a problem of excoriation to right buttock, the approaches included, but were not limited to, apply air mattress to bed, keep resident clean and dry at all times., provide care after each incontinent episode, and apply zinc oxide to buttock per orders. The care plan was updated on 3/27/11 with excoriation resolved. A care plan initiated on 3/17/11, indicated a problem of scab over healed old decubitus to right hip measuring 1 cm by 0.7 cm by 0 cm. The approaches included, but were not limited to, apply			

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air mattress to bed, avoid pressure to right hip, and apply zinc oxide as ordered. The care plan was updated on 3/27/11 with scab to right hip resolved.

A care plan initiated on 3/28/11, indicated a problem of blister to right heel related to shoes being too large. The approaches included, but were not limited to, apply heel protectors, avoid pressure to heels, keep heels free floating, apply lower air mattress to bed, notify family for need of smaller size shoe, and podiatrist will follow up with resident to re-evaluation.

A Weekly Wound Assessment Flow Record indicated 3/17/11 wound identified with the box marked yes. The location was the right buttock, staged indicated excoriation. The tissue was red. the treatment was zinc oxide and she had an air mattress and gel cushion as pressure relieving devices. On 3/27/11 the form indicated the area was healed.

A Weekly Wound Assessment Flow Record indicated 3/17/11 the box was checked for yes that a wound was identified. The location indicated right buttock and the the stage was un-stageable (scab). There was no assessment noted of the tissue color and no measurement was documented. There was no drainage or odor. The wound edges were in normal

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	limits and the surrounding tissue was normal. The treatment was zinc oxide and an air mattress and gel cushion were used for pressure relieving devices. On 3/27/11 the form indicated a check mark by the wound identified. The location was right buttock and the stage healing. The tissue color was cab off solid pink tissue. The area measured 2 cm by 4 cm by 0 cm. There was no drainage or odor. The wound edges were within normal limits and the surrounding tissue was within normal limits. the area was improved. The treatment was was zinc oxide and pressure relieving devices included an air mattress and gel cushion. On 3/28/11 there was a check in the box yes there was a wound identified. It was staged as a blister and the tissue color was fluid filled. There were no measurements indicated. There was no drainage and on odor. The wound edges were attached and the surrounding tissue was normal. The treatment of heel protectors and an air mattress was the pressure relieving device used. On 4/3/11 the box marked yes was check for a wound was identified. it was un-stageable and the blister had ruptured. There was nothing assessed for tissue color or measurements. There was a small amount of drainage that was serous in color. the edges were attached and the surrounding tissue was within normal limits. The treatment was zinc oxide,			

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	dressing and tape and heel protectors. The pressure relieving devices were low air mattress and heel protectors. There were no other Weekly Wound Assessment Flow Record for the right hip in the resident's chart or in the skin treatment book until 4/14/11 and no other flow records for the resident's right heel. A Weekly Wound Assessment Flow Record dated 4/14/11 indicated a check was placed in the box that a wound was identified to the right hip the tissue color was spongy and the area measured 1 cm by 1 cm by undetermined. There was a small amount of serosanguinous drainage (contains serum and blood) with no odor. the edges were attached and the surrounding tissue was normal. On 4/19/11 the right hip measured 1 cm by 1 cm by undetermined. The tissue was spongy with serosanguinous drainage and no odor. The treatment was changed to santyl cover with hydrogel and foam dressing twice a day. On 4/25/11 the right hip was pale red and measured 2.5 by 2 cm by undetermined. There was a small amount of serosanguinous drainage that had an odor and the wound was deteriorating. On 4/25/11 a wound had been identified to the coccyx area that was a Stage II. The area was beefy red measuring 1 cm by 1 cm by 0.2 cm. there			

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	was a small amount of serous (serum) drainage with no odor. A Weekly Wound Assessment Flow Record dated 3/20/11, indicated a check was placed in the box yes for wound identified to right buttock at a Stage II. The tissue was red and the area measured 1 cm by 0.7 cm by 0 cm. there was no drainage or odor. The edges were attached and the surrounding tissue was normal. The treatment was continue zinc oxide and the pressure relieving devices were air mattress and gel cushion. On 3/27/11 the right buttock area was a Stage II red in color, measuring 1 cm by 0.7 cm by 0 cm with no drainage or odor. The wound edges were attached and the surrounding tissue was normal. The treatment and pressure relieving devices were the same. On 4/3/11 the Right buttock was a Stage II red in color measuring 1 cm by 0.7 cm by O cm. There was no drainage no odor, the wound edges were attached and the surrounding tissue was normal. The treatment and pressure relieving devices were not changed. On 4/10/11 the right buttock was a Stage I measuring 0.7 cm by 0.3 cm by 0 cm. the tissue had epithelia growth with no drainage or odor. The edges were attached and the surrounding tissue was normal. There was no change in the treatment or the			

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	pressure relieving devices. There were no other Weekly Wound Assessment Flow Records for the right buttock. A Weekly Skin Assessment form indicated on 4/10/11 there was an open area to the right buttock measuring 0.7 cm by 0.3 cm by 0 cm. On 4/14/11 there was an open area to right hip 1 cm by 1 cm by 0 cm. There were two ruptured blister to the right heel measuring 4.5 cm by 3.5 cm by 0 cm and 3.5 cm by 4 cm by 0 cm. On 4/21/11 there was an open area to the right hip 1 cm by 1 cm by 0 cm and two ruptured blisters to the right heel measuring 4.5 cm by 3.5 cm x 0 cm and 3.5 cm by 4 cm by 0 cm. The Weekly Pressure Area, Blister or Skin Tear Measurement Schedule Policy was provided by the Director of Nursing on 5/25/11 at 1:15 p.m. The purpose: "To ensure the resident's skin condition heals to the optimal level as possible with skin becoming intact. Procedure: "1. Complete "Braden Scale" assessment form on admission, reassess quarterly there after and upon significant change. 2. If resident is identified at risk for alteration in skin integrity provide precautions/interventions to decrease the			

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	risk of pressure areas, blister, or skin tear. 3. Document specific problems, interventions and goals on resident's care plan. 4. Review and update the care plan with scheduled revisions of resident's condition changes. 5. If pressure area, blister or skin tear occurs, assess and document the weekly wound assessment: A. Location. B. Stage etc. C. Size (cm) length x (times) width. D. Wound depth (cm). E. Odor. F. Drainage. G. Admitted with pressure area or facility acquired. H. Physician notified and treatment order. I. Family notification. All stage III, IV and areas with eschar tissue will be referred to the Wound Nurse or Wound Clinic. 2. Weekly measurements will be recorded on the weekly wound assessment sheet. 3. Pressure Area Long Sheet will be completed monthly and given to the Director of nursing for Quality Assurance Meeting." On 5/25/11 at 1:00 p.m., the Director of Nursing (DoN) was interviewed she indicated that the above Weekly Wound Assessment Flow Record that included the right buttock and the right heel should not have indicated right buttock but right hip. She further indicated there must be a sheet of Weekly Wound Assessments Flow Record missing for the right hip and right heel. At this time the DoN indicated			

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	that there had been two areas to the right buttock: the 3/17/11 area that healed on 3/27/11, and the open area that was found on the right buttocks on 3/20/11. She further indicated she would look into where the Weekly Wound Assessment Flow Records were and provide the forms. On 5/25/11 at 2:00 p.m. the Weekly Wound Assessment Flow Records were requested again from the DoN. The DoN indicated she knew the missing Weekly Wound Assessment Flow Records had not been provided and would provide them. On 5/25/11 at 3:15 p.m., the DoN was interviewed. She indicated that when the resident returned to the facility on 4/14/11 the resident's hip wound was spongy and the scab was no longer present and there was a thin film like membrane where the scab had been located. "It was like there was something under the thin membrane." We were not going to break the membrane but the treatment was changed to santyl in hopes of opening it up. The wound nurse was in on 4/19/11 and changed the dressing again then over night on 4/25/11 the wound changed, and an order was received to go to the wound clinic. The soonest we could get her in was the next day. At 3:45 p.m. she requested the Social Service Director/Human Resource			

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	Manager to get the QA (quality assurance papers). The DoN indicated these forms would have the wound measurement that had been requested earlier in the day. She indicated this would be part of the resident's record because they were copies of the Weekly Wound Assessment Flow Record. The copies were provided. The DoN then indicated that the Weekly Wound Assessment Flow Records were different from the forms previously provided because she told staff that all information on one skin area was to be on one form. She did not want different wound areas on the same form. There was additional data provided on these forms that was not on the original forms that had been provided. At this time she also indicated the physician had seen the resident's wounds on 3/30/11 but had not been back in to the facility due to personal reasons, but the facility had the wound nurse come in and see the resident. This federal tag relates to Complaints IN00090539 and IN00090585. 3.1-40(a)(2)			

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F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to assess or plan care related to fall risk for a newly admitted resident who was a double amputee. The deficient practice affected 1 of 1 resident reviewed related to falls in a sample of 6. (Resident #E) Resident #E sustained a fall requiring treatment in the emergency room, including stitches to the hand. Findings include The record for Resident #E was reviewed on 5/24/11 at 11:45 a.m. The resident was admitted to the facility on 4/4/11. Her diagnoses included but were not limited to, diabetes mellitus, coronary artery disease, hypertension, left above the knee	F0323	F Tag 323 Free Of Accident Hazards/Supervision/Devices 1 What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident 1 fall assessment was completed immediately and nurse admission record updated with fall risk assessment. 2. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken. All medical records of residents fall assessments were audited and no other resident was found deficient. No other resident was affected. 3. What measures will be put into place or what systemic changes will be made to ensure that the deficient practice	06/24/2011

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	amputation, and right below the knee amputation. Review of the Admission Assessment for dated 4/4/11 at 4:00 p.m. indicated the section "History of Falls" was not completed. There were no boxes checked for the following areas: "if checked, further evaluation required per facility policy", "no history of falls", "fell in past 30 days", and "fell in past 31-180 days". A nursing note dated 4/30/11 at 6:49 a.m., indicated resident completed dinner and propelled self via wheelchair to room along with peers. The resident was found on floor, near door, crying. Staff assessed the resident for bruising and bleeding was noted to right forefinger. A nursing note dated 4/30/11 at 7:14 p.m., indicated the resident was transported to the hospital. A nursing note dated 4/30/11 at 11:56 p.m., indicated resident returned to the facility with new orders for Bactrim DS (antibiotic) one, by mouth, twice a day for seven days and Hydralazine (used to treat high blood pressure, hypertension) 100 mg (milligrams) one, by mouth, three times a day. The resident received four sutures to the laceration on her right forefinger.		does not recur. In Service on documentation for residents Fall Assessments on accuracy and completion was done. . 4. How the corrective action will be monitored to ensure the deficient practice will not recur. D.O.N. designee will monitor all admission nurse admission records and fall risk assessments upon admission and quarterly fall risk assessments. Director of Nursing and or designee will audit and monitor monthly and determine future in-service training needs. The D.O.N. will discuss progress How the corrective action will be monitored to ensure the deficient practice will not recur. The D.O.N. will discuss progress and concerns to the and concerns to the Q.A. Committee and the committee will determine effectiveness of the fall assessment policy and procedures. We are working on updating the computer system to include all assessments with the MDS program once the basic problems with the new 3.0 MDS system are corrected. 5. Completion Date: 6/24/2011 AddendumThe corrective action taken for resident E was a fall assessment was completed and a lap buddy is applied when up in wheelchair to prevent her from leaning to far foward. No other falls have occured with Resident EThe corrective action taken for residents having the potential to	

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	Interview with Social Service Director/Human Resource Manager on 5/25/11 at 8:25 a.m., indicated all area of the Resident Nursing Assessment form need to be completed. No area should be blank. Interview with LPN #1 on 5/25/11 at 8:35 a.m., indicated all areas of the Resident Nursing Assessment form were to be completed when a resident was admitted to the facility. No area should be blank. Interview with the Director of Nursing on 5/25/11 at 3:15 p.m., indicated the area on the Resident #E's resident nursing assessment form was blank and it should not have been, however there may have been another fall assessment completed. The facility had new computer programs and the assessment could be in the computer. At the exit conference on 5/25/11 at 4:00 p.m. the Director of Nursing indicated there was no fall assessment completed on the resident when she was admitted to the facility. This federal tag relates to Complaints IN00090539 and IN00090585. 3.1-45(a)(2)		be affected by falls is as follows: Fall Risk Assessment is completed upon admission and updated quarterly and as needed. If a resident falls a post fall assessment is done to determine any risk factors causing the resident to fall. If a resident is at risk for falling Physical Therapy will be consulted to determine what anti-falling devices are needed such as lap buddy, alarm sensor, low bed, bolsters and or wedges. The systemic measures put into place are all resident who are a high fall risk are monitored each shift for anti-falling devices. This is dicussed during shift to shift report and tour check. The resident is monitored throughout each shift 24 hours per day. Each shift is monitored by the charge nurse and any falls or incidents are reported to the D.O.N. immediately. The D.O.N. will monitor the fall risk assessments and anti fall devices weekly times 1 month then monthly for six months to ensure ongoing compliance.	

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